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Encouraging Purchasing Pool Options

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Executive Summary

This option involves pooled and centrally administered purchasing of health coverage on behalf of, or by, large populations of individuals, families, or small businesses. Pooling is predicated on three separate but related assumptions:

- Large populations (of individuals, families, or businesses) should be able to obtain lower cost health products and services through volume purchasing arrangements and should be able to obtain more affordable health care coverage by spreading the risk of claims.
- Volume purchasing may provide economies of scale in administration by centralizing enrollment, premium collection, marketing, negotiating, and contracting functions.
- Stimulating price and quality competition among plans—through increased choice of coverage for participating groups and individuals— will contain costs.

On the surface, purchasing pools simply require a reorganization of health insurance purchasing mechanisms. However, the available evidence suggests that for this option to successfully increase health insurance coverage may require public subsidies, coverage requirements for individuals and businesses (e.g., mandating participation by certain groups of employees), dedicated regulations regarding rating and access, internal policies such as risk adjustment, and some standardization of benefits.

There are five major forms of purchasing pools are considered:

- Employer-based pools
- Individual or individual/small-group, market-based pools
- Other community-rated pools
- Mobile worker pools
- Consolidated, state-funded pools

Most of these pooled purchasing approaches exist in Washington State and elsewhere in the country, but the number of people and groups covered remains limited.

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Encouraging Purchasing Pool Options

Overview of Policy Option

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

Encouraging the use of purchasing pools would involve efforts to encourage collective purchasing (pool formation) among groups of businesses (large, medium, or small groups), individuals, and families or some combination of these groups. Although purchasing pools exist in the public and the private sectors, using pools specifically to expand coverage to those now uninsured may require new regulations or public subsidies to attain stable claim risk and pricing and economies of scale.

The concept of pooling in health insurance assumes that large populations (of individuals, families, or businesses) will be able to obtain lower cost and higher quality products and services through volume purchasing arrangements and can obtain more affordable health care coverage by spreading the risk of claims. Our analysis of purchasing pools focuses on the use of pools to buy health insurance, rather than pooling to purchase services directly from providers at discounted prices (e.g., through prescription drug card programs).

Problem Definition and Target Population

Why target this policy option?

Pooling offers the possibility of obtaining health insurance, or targeted health services, at lower cost—through the workings of shared/spread risk and volume purchasing (which yields certain economies of scale). This would, in turn, lower the average cost of coverage or of selected health services to buyers. It also provides opportunities for individuals and smaller employers to obtain coverage designed and administered for them and could be a vehicle to allow people to maintain coverage through life (especially work) transitions, thus at least partially unlinking coverage from employment.

Who is affected by this policy option?

A number of pools operate in Washington State and around the country. Purchasing pools could target specific groups, such as small businesses, self-employed individuals, low-wage workers, or all residents of a specific community. Health insurance purchasers (individuals and businesses) and insurers are affected by this policy option, as it may expand coverage options for some purchasers and open up new or expanded markets to insurers. Pools may affect governments by lowering demand for government-sponsored coverage. However, it may also increase demand on the government for subsidies, new laws, and special arrangements for the uninsurable. Depending on the type of pool(s) used, virtually all of the uninsured in Washington could be affected.

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Policy Design Options and Considerations

Potential ways to (re)design purchasing pools might be based on:

- Employer sponsorship (employer-based pools)
- Status as an individual or small group (individual or individual/small-group market pools)
- Involvement in other communities—e.g., residency in the Tri-Cities area or school district—(other community-rated pools)
- Common workforce membership to address changing employer needs and the needs of mobile workers (as with Taft-Hartley groups and MEWAs, or potentially through mobile worker pools)
- Consolidation of state-funded programs such as the PEBB plan for certain public employees and retirees, with Medicaid for the indigent (consolidated state-funded pools)

The design of purchasing pools builds on a basic concept of insurance, grouping large numbers of persons to spread and share the risk of definable and predictable events and their associated costs. Further, pooling appears to offer opportunities for providing economies of scale in administration (e.g., for marketing and enrollment processes, meeting disclosure requirements, administering claims) and for gaining a price advantage by using collective purchasing power to negotiate discounts with providers. Purchasing pools may also provide an infrastructure to promote managed competition, which requires a choice of plans, appropriate financial incentives, and information. Small businesses are typically unable to offer choice and do not have resources to gather and disseminate information.

However, pooling in and of itself may not provide economies with regard to benefit costs, the largest component of health insurance spending, if the participating population is sicker, prone to using more services, or inclined toward using higher cost services. This has been an ongoing concern when the rules of the marketplace—whether driven by regulation or *de facto* practices—allow for different underwriting and rating approaches within and outside pools.

Public/private roles or accountabilities and opportunities for partnership

At present, the public sector addresses pools in multiple ways. Certain public entities (e.g., counties, public school districts) purchase coverage for their employees and retirees through existing pools (e.g., the Washington Counties Insurance Fund, the PEBB). The state also pools funds to obtain coverage for certain low-income populations (e.g., Basic Health). The Office of the Insurance Commissioner reviews insurers, HMOs, and health care service contractors that essentially pool their clients; it also monitors certain association purchasing arrangements. Additionally, the state sponsors and monitors, but generally does not subsidize, the Washington State Health Insurance Pool (also known as the *high-risk pool*).

Certain multiple employer welfare associations (MEWAs), unions, and labor-management trusts (called Taft-Hartley Trusts) may become self-insured and, therefore, exist outside the purview of state insurance laws. These associations and trusts arise when similar organizations consolidate their benefits funds or purchase their coverage together, recognizing that their employees come from a single, although fluid, specialized workforce pool. For example, construction industry employers and unions may use a specialized trust arrangement because their workers move from

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one employer to another as projects or seasons change. By participating in these arrangements, employees can continue coverage despite changes in employers, hours worked, and so on. As such, MEWAs and Taft-Hartley Trusts represent a model of pooling that transcends employment transitions. MEWAs and Taft-Hartley Trusts are subject to the federal Employee Retirement Income Security Act (ERISA) of 1974 and the Labor-Management Relations Act of 1947 (known as the Taft-Hartley Act), as amended, but may be exempt from state regulation, thereby not directly accountable to Washington State.

Financing considerations

Except under unusual circumstances, for example, with regard to the high-risk pool, pools are expected to rely on conventional funding approaches, with participants (employers and individuals) responsible for costs, and risk-bearing entities (e.g., insurers or the pools themselves) taking risk. Matching funds, or grants, would not serve as funding sources. However, many states that have implemented small-group purchasing alliances have provided start-up funds for their establishment. Some also view pools as a way to effectively administer the financing of premiums from a variety of sources such as public subsidies, employer contributions, and employee contributions. This may facilitate movement between public and private programs as well as the coordination of public and private programs. The Kansas alliance is an example of such an initiative (Curtis, et al., 2001).

Administrative considerations

A workable pooling arrangement requires the development of agreed upon eligibility rules, enrollment and disenrollment rules, and employer contribution requirements, to the extent employment relationships factor into the pooling approach. Important considerations also include plan design(s), coverage tier pricing, and provider networks, as these affect the marketability of the program. Other administrative considerations are the role of the existing distribution network, the number of service areas, the role of the alliance in gathering and distributing information, and whether to contract selectively or with all willing plans. Some of the tradeoffs of these choices are shown in Figure 1, below. A major issue, however, is the extent to which employment relationships can serve as the basis for requiring pool participation. This issue was explored, but not resolved, when Washington State pursued health care reform in the early 1990s.

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Figure 1. Pooled Purchasing Arrangements: Design Choices

Design Choice	Options and Issues
Eligibility	**All employers vs. size restriction**
	Including large employers promotes greater risk pooling.
	Including all employers helps break insurance/employment link.
	Including all employers may be viewed as monopsony and lead to regulatory limits on ability to negotiate.
	Participation in alliances by large business may diminish their role as innovators in cost-containment and quality.
	Employers and individuals
	Facilitates continuity of coverage through transitions.
	Extending to all employees may undermine existing employer-sponsored arrangements.
	Offering new pooled arrangements to select groups (e.g., working persons currently ineligible for employer plans or employer-subsidized coverage) could provide a new coverage option.
	Selection concerns in pooling employer and individual market, especially when different regulatory provisions apply.
Selective contracting vs. contracting with all willing plans	Selective contracting may be needed to realize price advantage.
	Concerns about alliance monopsony power with selective contracting.
Role of brokers and existing distribution system	Broker involvement likely necessary for success given important role they play in small group and individual market.
	Broker involvement reduces potential administrative cost savings.
Governance, role of state	State start-up funds and sponsorship may be necessary to implement and maintain.
	Insurer concerns about state involvement cited as factor in collapse of Florida CHPAs.
Collection and provision of information, "report cards"	Essential element of managed competition model, but costly for alliances to do and raises administrative costs.
Number of service areas	Advantage of local control vs. cost savings from centralization.
Mandatory vs. voluntary participation	Greater risk spreading with mandatory participation.
	Reduced adverse selection issues with mandatory participation.
	Greater economies possible with mandatory participation.
	Voluntary participation maintains marketplace diversity and promotes competition.

Evidence and Theory on Effects

Generally, both the theoretical literature and empirical tests show that most pools rely on employment relationships, individual/small-group market purchasing arrangements, and other community-based options (e.g., based on income or health risk in areas served by particular programs). The literature is summarized below, and evidence on specific pooling issues is summarized in a table in Appendix A.

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Pooling generated substantial interest during the health care reform efforts of the Clinton Administration, particularly as conceived by the Jackson Hole Group in the early 1990s. A primary proposal was to organize "health insurance purchasing cooperatives" (HIPCs), a form of purchasing pool, to "enhance the purchasing power of small employers and individuals and provide greater choice of plans, creating more competitive markets." (Tollen and Crane, 2001). The optimal functioning of HIPCs was expected to require the following features, although most HIPCs never operated under all these conditions.

- Exclusive provider networks
- Mandatory participation in HIPCs
- Insurance market reforms (e.g., regarding the economic valuation/pricing of a minimum benefit package, limits on premium increases)
- A standardized (minimum) benefit package to foster "apples-to-apples" price and provider competition*
- Integration of health care delivery and financing mechanisms
- Subsidies for certain individuals and groups based on the lowest cost plan available
- Universal coverage

States have since adopted certain aspects of this optimal approach, regulating rating approaches in the small-group market to maintain the affordability of coverage. Pools themselves implement rules to avoid declining participation and increasing risk.

The descriptive and analytic literature suggests that the advantages many pools provide participants are plan choice and administrative simplicity rather than reduced price—especially when pools are forced to respond to market demands for provider choice and rich benefits. Many insurers are prohibited from offering lower prices in and out of the alliance except those accounted for by administrative efficiencies, and many pools are precluded from selectively contracting and negotiating volume discounts. Hence price advantages are restricted to administrative savings stemming from economies of scale.

Few pools have garnered sufficient market share to capture such administrative savings. (Wicks, et al., 2000; Long and Marquis, 2001) In fact, Tollen and Crane suggest that pools may actually be more expensive, because they provide expanded administrative services to purchasers (e.g., added marketing and educational efforts) and are not as stringent as insurers in pricing their products because of their quasi-"public service mission." These authors suggest that to improve access to pooled insurance through price, it might be reasonable to explore reduced benefit requirements, the use of small-group pricing reforms, alternate risk adjustment approaches, subsidies for certain participants who purchase the most basic pool coverage available, and tax incentives for participating employers and individuals to remain insured.

Some purchasing pools that were permitted to contract selectively did gain a price advantage for participating employers. The California alliance aggressively negotiated with insurers for lower premiums and experienced substantial early savings for participants (Yegian et al., 2000; Long and Marquis, 2001). The Minnesota Buyers Health Care Action Group negotiated contracts

* A standardized benefit package for its HMO products is used by the PEBB to foster price, network, and quality competition. The PEBB supplements this approach with risk-adjusted payment requirements.

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directly with care systems rather than with insurers. Preliminary information suggested that the group did provide savings to participating employers (Christianson, et al., 1999).

Though most pools have failed to gain a price advantage for participants, many observers believe that their presence promoted competition in the market, leading to overall lower prices for small employers. Most pools adopted managed competition principles. In a review of six HIPCs throughout the country, Wicks and Hall (2000) point out that purchasing cooperatives have had a strong potential for successfully providing choice to small-firm workers, an essential ingredient of managed competition. Employee choice of health plans is generally not feasible for small employers, because such options typically lead to increased administrative burdens. HIPCs offer this option at no extra cost to interested employers and, in some cases, require that employers offer individual choice. Moreover, most purchasing pools provided price and quality information to promote effective consumer decision-making. However, although informed opinion supports the existence of spill-over benefits to the market as a whole from the presence of alliances, empirical analysis does not confirm this belief (Wicks, et al., 2000; Long and Marquis, 2001).

Other experts (Curtis, et al., 2000) suggest that pools be required in specified geographic areas as "the only venue through which individual tax credits [the primary financing mechanism for low-income persons] could be used to purchase health insurance." Accordingly, pools would focus instead on select groups (e.g., subsidized, low-income individuals and small employers), providing economies of the large-group market (5 percent to 10 percent lower premiums than available in the small-group market), as well as expanded choice and access to ongoing coverage. This approach, however, would require participation by the lower-income population, substantial public or charitable funding for start-up costs, federal income tax law change, changes in state insurance law, and the definition of a universal benefit floor. It would also appear to require changes to ERISA to allow for a small-group (employer) mandate.

The U.S. GAO supported the notion of purchasing cooperatives in 1994, citing experience around the country by public and private pools. The GAO found that although the governance of some of these pools had become politicized, their operating (administrative) costs were relatively modest because staffs were small, focused on overall policy making and management function.† Pauly and Herring (1999) seem to have found an opposite effect. They note that risk pooling is already widespread beyond the group market as survey data indicate that the premiums paid by individuals do not necessarily correlate with their risk. In many cases, the costs of administration in the individual and small-group markets serve to raise premiums beyond the average health risk of the purchasers or the benefit available. Thus, collective purchasing in the individual insurance market that would lower the administrative costs would be a direction for expanding insurance coverage

A recent study of six states trying to expand employment-based health coverage (Silow-Carroll et al., 2001) noted the risk that purchasing pools could inadvertently become high-risk pools in the absence of mechanisms to maintain participation (e.g., premium subsidies or subsidies for excess loss). It also cautioned against having voluntary programs, recommending that the provision of subsidies avoid the possibility that public funds will "crowd out" privately purchased insurance. How the federal ERISA might affect such pools was not fully addressed.

† This paper did not address the administrative costs of the plans that were actually being offered.

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For purposes of using pools to expand access to health insurance, Washington State Basic Health (BH) provides perhaps the best example of pooling potential for individuals and small businesses that do not want to offer their own medical benefit packages. However, BH provides limited coverage and requires substantial public subsidies for most members. Further, despite the long-standing availability of BH, a sizeable percentage of potentially eligible Washington State residents remains uninsured, primarily because the state Legislature has not authorized additional subsidized enrollment slots (although Initiative 773, passed by voters in November 2001, did provide additional funding to add some subsidized slots).

Washington State Context and History

MEWAs, unions, Taft-Hartley Trusts, and Basic Health offer models of pooled purchasing that can provide coverage despite transitions in employment status, one of the major barriers in the current health care financing system. Except for Basic Health, these types of pooled purchasing arrangements, as well as the Blues, Group Health Cooperative, and private carriers, have operated for decades.

Additionally, the state explored the possibility of developing HIPCs here, following broad health care reform legislation in 1993. An important part of this reform was to ensure at least a minimum level of health coverage for all Washingtonians (Crittenden, 1995). Before most Washington State health care reform efforts were discontinued in 1995, preliminary analysis suggested that, among other obstacles, the HIPCs envisioned in reform could not be mandated for employers due to ERISA preemptions. Additionally, significant public subsidies would be needed to pay for the coverage of many state residents. Although some additional funding has been provided to expand coverage through Basic Health, SCHIP and other state programs, widely expanded public funding would not appear to be forthcoming in the foreseeable future.

A number of Washington State pooling arrangements currently exist through “associations.” Illustrative information on associations is summarized in Appendix B.

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Summary of Findings and Implications

Pooling offers the possibility of increasing access to health insurance. Selected ways of organizing these pools, and important considerations about them, other than those previously discussed, are listed below:

Type of Pool	Important Considerations
Employer-based pools	Already available through self-insuring. Administrative and legal complexities need to be weighed against potential economies.
Individual or individual/small-group, market-based pools	Already available through some voluntary programs, such as AWB and Employers' Health Purchasing Cooperative, and Basic Health.
Other community-rated pools	Would need to define "community" and associated enrollment, eligibility, and other rules. Could cause loss of coverage for those no longer part of the "community."
Mobile worker pools	Available in selected industries (e.g., wood products, construction) through MEWAs, unions, or Taft-Hartley plans. Would require significant changes in how benefits are provided or sponsored in other industries (e.g., health care, high technology) to get larger employers to participate.
Consolidated, state-funded pools	Would likely require new rules and procedures to account for different eligibility rules, claim risk levels, subsidies, and other features among participating subgroups.

To achieve the benefits of pooling:

- Pooling entities must build upon existing distribution networks (e.g., including the involvement of brokers/agents working with businesses and individuals).
- Regulatory changes, such as rating and access reforms, may be needed to "even the playing field" between the pool and the external market with regard to underwriting and rating practices.
- Internal policies (such as risk adjustment mechanisms) will be needed to "even the playing field" between participating insurers.
- Pools must establish a large enough base to realize scale economies and to attract plans to participate. Beginning with an established pool—such as that covering government workers—offers one approach.
- Pools probably should require participation of certain eligible groups or individuals and provide subsidies to attract and maintain participation.
- The political or fiscal feasibility of mandating participation in and providing public subsidies to pools (for either start-up capitalization or ongoing premium control) is uncertain at this time.

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Appendix

Appendix A. Evidence and References Concerning Purchasing Pools

Appendix B. Characteristics of Washington State Purchasing Pools for Medical Coverage, December 2001

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Appendix A. Evidence and References Concerning Purchasing Pools

Issue	Evidence	Reference
Operational		
Selection		
Into pool	Adverse selection reported if different underwriting and rating rules in and out of pool	Wicks, et al. (March 2000)
	Little empirical evidence of selection when rules are the same	Long & Marquis (Jan/Feb 2001)
Within pool (e.g., among plans offered)	Cited as factor for plan withdrawal in California and Florida	Long & Marquis (Jan/Feb 2001) Silow-Carroll, et al. (Feb 2001) Wicks, et al. (March 2000) Yegian, et al. (Sep/Oct 2000)
Promoting managed competition		
Use of information	Element of most small group alliances	Wicks, et al. (1994)
Offering choice	Most small group alliances require employers make a choice available	Long & Marquis (Jan/Feb 2001) Wicks & Hall (2000) Wicks, et al. (1994)
Effectiveness		
Price in pool	Lower when plans can selectively contract	Christianson, et al. (Nov/Dec 1999) Long & Marquis (Jan/Feb 2001) Wicks, et al. (March 2000) Yegian, et al. (Sep/Oct 2000)
Competitive effects on market	Widely believed to be the case by experts Empirical evidence doesn't support assertion	Wicks, et al. (March 2000) Long & Marquis (Jan/Feb 2001)
Reducing the uninsured	Little evidence of reductions	Wicks, et al. (March 2000) Long & Marquis (Jan/Feb 2001)
Barriers to Success		
Market share	Few pools have garnered sufficient share to realize economies of scale	Long & Marquis (Jan/Feb 2001) Curtis, et al. (Jan/Feb 2001)
Plan participation	Plans reluctant to join because of adverse selection, price negotiations, price competition	Hall, et al. (Jan/Feb 2001)
Broker cooperation	Brokers do not promote alliance	Long & Marquis (Jan/Feb 2001)
	Early broker cooperation necessary for success	Curtis, et al. (Jan/Feb 2001) Wicks, et al. (March 2000)
Governance	Close connection with state viewed unfavorably by insurers	Curtis, et al. (Jan/Feb 2001) Wicks, et al. (March 2000)

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Appendix B. Characteristics of Washington State Purchasing Pools for Medical Coverage, December 2001

Organization Name (Year of Pool Inception) Web site Address and Approximate Enrollment (as of December 2001)	Employer Eligibility and Underwriting Requirements (if applicable)	Individual/Employee Eligibility and Underwriting Requirements	Funding	Major Plan Offerings
Association of Washington Businesses (1996) www.awb.org Enrollment not available	Available to employers with 2-50 employees (husband and wife can qualify if both work in business).	Not available.	Combination of employer and employee contributions.	Choice of four insured plans: • Two PPO plans available . • Two catastrophic health care plans available.
Basic Health Plan (1997) www.wa.gov/hca/basichealth.htm 130,000 (subsidized only)	Eligible participants may join through a participating home care agency or financial sponsor (group). Employers enrolling employees in Basic Health group coverage must pay a minimum of $45 per employee and $25 per part-time employee.	Subsidized coverage: Must live in Washington, be Medicare-ineligible, within Basic Health's income guidelines and not institutionalized. Unsubsidized coverage: May join on a self-pay basis.	Subsidized portion of program funded through state, individual, and employer contributions, if applicable.	Choice of eight plans with standardized benefit package through private managed care plans.
Employers Health Purchasing Cooperative (1994) www.ehpc.com 15,000	Employer must become a dues paying co-op member, have at least two employees and pay specified initiation and monthly administrative fees. • Employer must also agree to purchase EHPC coverage for three years. • Employer must pay at least 50% of employee premium.	Employees must be regular, full-time employees who work at least 20 hours a week. At least 75% of eligible employees must enroll (100% for groups with two or three employees). At least 90% of eligible employees must reside in the network service area.	Combination of employer and employee contributions.	Employer has choice of two plan groupings. Within each plan, employee has choice of three benefit designs.
Public Employees Benefit Board (1988) www.wa.gov/hca/pebb.htm 313,000	• Required for state and higher education units; • Voluntary for K-12 school districts and other political subdivisions of the state. Voluntarily participating entities must remain at least one full "plan"/contract year.	• Employees of these public entities must work at least 0.5 FTE. • 100% of eligible employees must enroll if group coverage is purchased.	Combination of employer and employee contributions.	• One self-insured PPO. • Eight private market managed care plans.

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Organization Name (Year of Pool Inception) Web site Address and Approximate Enrollment (as of December 2001)	Employer Eligibility and Underwriting Requirements (if applicable)	Individual/Employee Eligibility and Underwriting Requirements	Funding	Major Plan Offerings
Seattle-King County Chamber of Commerce (1982) www.seattlechamber.com/membership/benefits_costsav.cfm Enrollment not available	Puget Sound region businesses of 1 to 99 employees who pay annual membership dues based on size.	Not available.	Combination of employer and employee contributions.	Choice of several PPO and POS plans.
Washington Alliance for Healthcare Insurance Trust (WAHIT) (1997) www.wahit.com 47,000	Employer that regularly employs between 5 and 99 employees.	Employees who work 20 or more hours a week and are paid on a regular basis through the employer's payroll system. If 100% employer contribution, 100% participation required. If 75% - 99% employer contribution, 75% minimum participation required.	Combination of employer and employee contributions.	Choice of three PPO plans.
Washington Counties Insurance Fund (WCIF) (1958) www.wacounties.org 20,000	Washington county and special district employers.	Not available.	Combination of employer and employee contributions.	Choice of three PPO plans and two POS plans.
Washington Education Association (WEA) www.wa.nea.org 47,000	Must be a public school district (or bargaining group).	Must be benefit eligible.	Combination of employer and employee contributions.	Choice of three PPO plans and one HMO plan.
Washington Software Alliance (WSA) (1989) www.wsa.benenet.net 7,500	Washington software, Internet, and technology companies.	Determined by each carrier.	Combination of employer and employee contributions.	Choice of three PPO plans and two POS plans.
Washington State Health Insurance Pool – "High-Risk Pool" (1987) 2,200	N/A	If declined from coverage due to medical risk (now top 8% of applicants in terms of expected cost).	Individual participants. Funded by assessments on insurers (based on their market share and loss assessment).	Choice of two plans.

Note:
1. Most of the purchasing pools listed in the table above are offered statewide.
2. Effective January 1, 2001, the Washington Bankers Association (WBA) Employee Benefit Trust joined with the benefit programs of the Washington Independent Community Bankers Association. Accordingly, we do not show information pertaining to the discontinued pooling arrangement of the WBA. Information on the replacement program was not released to Mercer.

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3. Another pooled arrangement operated by the Washington Hospital Insurance Trust no longer offers medical coverage and is not reported above.

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